

**NATIONAL MEDICAL SUPPORT NOTICE  
PART B  
MEDICAL SUPPORT NOTICE TO PLAN ADMINISTRATOR**

This Notice is issued under section 466(a)(19) of the Social Security Act, section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974, and for State and local government and church plans, sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998. Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under applicable law. The rights of the parties and the duties of the plan administrator under this Notice are in addition to the existing rights and duties established under such law.

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| <b>Issuing Agency:</b> Alaska Child Support Services Division<br><b>Issuing Agency Address:</b> 550 W 7th Ave<br>Anchorage AK 99501<br><br><b>Date of Notice:</b><br><b>Case Number:</b><br><b>Telephone Number:</b> 907-269-6901<br><b>FAX Number:</b> 907-269-6914 | <b>Court or Administrative Authority:</b><br><b>Date of Support Order:</b><br><b>Support Order Number:</b> |
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|                                                                                                    |            |                                                                                                                                                                                        |
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| <b>Employer/Withholder's Federal EIN Number</b>                                                    | <b>RE:</b> | <b>Employee's Name (First MI Last)</b>                                                                                                                                                 |
| <b>Employer/Withholder's Name</b>                                                                  |            | <b>Employee's Social Security Number</b>                                                                                                                                               |
| <b>Employer/Withholder's Address</b>                                                               |            | <b>Employee's Mailing Address</b>                                                                                                                                                      |
| <b>Custodial Parent's Name (First, MI, Last)</b>                                                   |            | <b>MS 01</b><br><b>Alaska Child Support Services Division</b><br><b>550 W 7TH AVE STE 310</b><br><b>ANCHORAGE AK 99501-6699</b><br><b>Substituted Official/Agency Name and Address</b> |
| <b>Custodial Parent's Mailing Address</b>                                                          |            |                                                                                                                                                                                        |
| <b>Child(ren)'s Mailing Address (if different from Custodial Parent's)</b>                         |            |                                                                                                                                                                                        |
| <b>Name, Mailing Address, and Telephone</b><br><b>Number of a Representative of the Child(ren)</b> |            |                                                                                                                                                                                        |
| <b>Child(ren)'s Name(s)</b>                                                                        | <b>DOB</b> | <b>SSN</b>                                                                                                                                                                             |

The order requires the child(ren) to be enrolled in (X) any health coverages available; or ( ) only the following coverage(s):     Medical;     Dental;     Vision;  
    Prescription drug;     Mental health;     Other (specify):

## PLAN ADMINISTRATOR RESPONSE

(To be completed and returned to the Issuing Agency within 40 business days after the date of the Notice, or sooner if reasonable)

This Notice was received by the plan administrator on \_\_\_\_\_.

- ( ) 1. This Notice was determined to be a "qualified medical child support order," on \_\_\_\_\_ **Complete Response 2 or 3, and 4, if applicable.**
2. The participant (employee) and alternate recipient(s) (child(ren)) are to be enrolled in the following family coverage.
- ( ) a. The child(ren) is/are currently enrolled in the plan as a dependent of the participant.
- ( ) b. There is only one type of coverage provided under the plan. The child(ren) is/are included as dependents of the participant under the plan.
- ( ) c. The participant is enrolled in an option that is providing dependent coverage and the child(ren) will be enrolled in the same option.
- ( ) d. The participant is enrolled in an option that permits dependent coverage that has not been elected; dependent coverage will be provided.

Coverage is effective as of \_\_\_/\_\_\_/\_\_\_ (includes waiting period of less than 90 days from date of receipt of this Notice). The child(ren) has/have been enrolled in the following option:

\_\_\_\_\_. Any necessary withholding should commence if the employer determines that it is permitted under State and Federal withholding and/or prioritization limitations.

- ( ) 3. There is more than one option available under the plan and the participant is not enrolled. The Issuing Agency must select from the available options. Each child is to be included as a dependent under one of the available options that provide family coverage. If the Issuing Agency does not reply within 20 business days of the date this Response is returned, the child(ren), and the participant if necessary, will be enrolled in the plan's default option, if any:  
\_\_\_\_\_.
- ( ) 4. The participant is subject to a waiting period that expires \_\_\_/\_\_\_/\_\_\_ (more than 90 days from the date of receipt of this Notice), or has not completed a waiting period which is determined by some measure other than the passage of time, such as the completion of a certain number of hours worked (describe here: \_\_\_\_\_). At the completion of the waiting period, the plan administrator will process the enrollment.
- ( ) 5. This Notice does not constitute a "qualified medical child support order" because:
- ( ) The name of the ( ) child(ren) or ( ) participant is unavailable.
- ( ) The mailing address of the ( ) child(ren) (or a substituted official) or ( ) participant is unavailable.
- ( ) The following child(ren) is/are at or above the age at which dependents are no longer eligible for coverage under the plan \_\_\_\_\_ (insert name(s) of child(ren)).

Plan Administrator or Representative:

Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Case Number:  
Employer ID:

## INSTRUCTIONS TO PLAN ADMINISTRATOR

This Notice has been forwarded from the employer identified above to you as the plan administrator of a group health plan maintained by the employer (or a group health plan to which the employer contributes) and in which the noncustodial parent/participant identified above is enrolled or is eligible for enrollment.

This Notice serves to inform you that the noncustodial parent/participant is obligated by an order issued by the court or agency identified above to provide health care coverage for the child(ren) under the group health plan(s) as described on **Part B**.

(A) If the participant and child(ren) and their mailing addresses (or that of a Substituted Official or Agency) are identified above, and if coverage for the child(ren) is or will become available, this Notice constitutes a "qualified medical child support order" (QMCSO) under ERISA or CSPIA, as applicable. (If any mailing address is not present, but it is reasonably accessible, this Notice will not fail to be a QMCSO on that basis.) You must, within 40 business days of the date of this Notice, or sooner if reasonable:

(1) Complete Part B - Plan Administrator Response - and send it to the Issuing Agency:

(a) if you checked Response 2:

- (i) notify the noncustodial parent/participant named above, each named child, and the custodial parent that coverage of the child(ren) is or will become available (notification of the custodial parent will be deemed notification of the child(ren) if they reside at the same address);
- (ii) furnish the custodial parent a description of the coverage available and the effective date of the coverage, including, if not already provided, a summary plan description and any forms, documents, or information necessary to effectuate such coverage, as well as information necessary to submit claims for benefits;

(b) if you checked Response 3:

- (i) if you have not already done so, provide to the Issuing Agency copies of applicable summary plan descriptions or other documents that describe available coverage including the additional participant contribution necessary to obtain coverage for the child(ren) under each option and whether there is a limited service area for any option;
  - (ii) if the plan has a default option, you are to enroll the child(ren) in the default option if you have not received an election from the Issuing Agency within 20 business days of the date you returned the Response. If the plan does not have a default option, you are to enroll the child(ren) in the option selected by the Issuing Agency.
- (c) if the participant is subject to a waiting period that expires more than 90 days from the date of receipt of this Notice, or has not completed a waiting period whose duration is determined by a measure other than the passage of time (for example, the completion of a certain number of hours worked), complete Response 4 on the Plan Administrator Response and return to the employer and the Issuing Agency, and notify the participant and the custodial parent; and upon satisfaction of the period or requirement, complete enrollment under Response 2 or 3, and
- (d) upon completion of the enrollment, transfer the applicable information on Part B - Plan Administrator Response to the employer for a determination that the necessary employee contributions are available. Inform the employer that the enrollment is pursuant to a National Medical Support Notice.

(B) If within 40 business days of the date of this Notice, or sooner if reasonable, you determine that this Notice does not constitute a QMCSO, you must complete Response 5 of Part B - Plan Administrator Response and send it to the Issuing Agency, and

inform the noncustodial parent/participant, custodial parent, and child(ren) of the specific reasons for your determination.

- (C) Any required notification of the custodial parent, child(ren) and/or participant that is required may be satisfied by sending the party a copy of the Plan Administrator Response, if appropriate.

### **UNLAWFUL REFUSAL TO ENROLL**

Enrollment of a child may not be denied on the ground that: (1) the child was born out of wedlock; (2) the child is not claimed as a dependent on the participant's Federal income tax return; (3) the child does not reside with the participant or in the plan's service area; or (4) because the child is receiving benefits or is eligible to receive benefits under the State Medicaid plan. If the plan requires that the participant be enrolled in order for the child(ren) to be enrolled, and the participant is not currently enrolled, you must enroll both the participant and the child(ren). All enrollments are to be made without regard to open season restrictions.

### **PAYMENT OF CLAIMS**

A child covered by a QMCSO, or the child's custodial parent, legal guardian, or the provider of services to the child, or a State agency to the extent assigned the child's rights, may file claims and the plan shall make payment for covered benefits or reimbursement directly to such party.

### **PERIOD OF COVERAGE**

The alternate recipient(s) shall be treated as dependents under the terms of the plan. Coverage of an alternate recipient as a dependent will end when similarly situated dependents are no longer eligible for coverage under the terms of the plan. However, the continuation coverage provisions of ERISA or other applicable law may entitle the alternate recipient to continue coverage under the plan. Once a child is enrolled in the plan as directed above, the alternate recipient may not be disenrolled unless:

- (1) The plan administrator is provided satisfactory written evidence that either:
  - (a) the court or administrative child support order referred to above is no longer in effect, or
  - (b) the alternate recipient is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment from the plan;
- (2) The employer eliminates family health coverage for all of its employees; or
- (3) Any available continuation coverage is not elected, or the period of such coverage expires.

### **CONTACT FOR QUESTIONS**

If you have any questions regarding this Notice, you may contact the Issuing Agency at the address and telephone number listed above.

### **Paperwork Reduction Act Notice**

The Issuing Agency asks for the information on this form to carry out the law as specified in the Employee Retirement Income Security Act or the Child Support Performance and Incentive Act, as applicable. You are required to give the Issuing Agency the information. You are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Issuing Agency needs the information to determine whether health care coverage is provided in accordance with the underlying child support order. The Average time needed to complete and file the form is estimated below. These times will vary depending on the individual circumstances.

#### **Learning about the law or the form**

First Notice      1 hr.

Subsequent Notices      -----

#### **Preparing the form**

1 hr., 45 min.

35min.